Major Initiatives and Subprograms

Major Sections: Page

The NC Medicaid program has developed a number of initiatives and subprograms to meet federal or state government mandates, to respond to recipient lawsuits, to meet specific medical needs identified among Medicaid recipients or to give recipients better access to care or more care options. Some of these programs are only available to specific groups of recipients, such as pregnant women, and some are available to all. Services under the various subprograms are not necessarily mutually exclusive; a recipient may be eligible to receive services from a number of subprograms.

Managed Care

Managed care options for Medicaid recipients are available in all 100 North Carolina counties. Most, but not all, Medicaid eligibles qualify for managed care. As of June 2004, there were 776,396 Medicaid eligibles enrolled in a managed care plan out of a total of 1,030,014 Medicaid **managed care eligibles**, or approximately 75%. Managed care program options include Carolina ACCESS and Community Care of North Carolina.

Eligibility to participate in a managed care plan is mandatory for a majority of Medicaid recipients in North Carolina. Although recipients of Medicaid who are dually eligible for Medicaid and Medicaid are optionally enrolled in Carolina ACCESS, they are not enrolled in HMOs. Medicaid recipients who are in long term care facilities are not enrolled in any managed care plan.

- **Community Care of North Carolina** (formerly Carolina ACCESS) – A primary care case management model characterized by a primary care provider gatekeeper. Community Care expands the traditional managed care model by working with local providers and networks to better manage the Medicaid population with processes that impact both the quality and cost of health care. This program was originally created as a health care demonstration project by the NC Office of Research, Demonstrations, and Rural Health Development, and is currently a joint collaborative effort between that office and DMA.

- **Healthcare Connection/Risk Contracting** – A program operating in Mecklenburg County requiring a majority of the Medicaid recipients in the county to enroll in the HMO, Carolina ACCESS or Community Care of North Carolina. The recipient is free to choose one of these options. DMA contracts with an HMO in Mecklenburg County to provide and coordinate medical services for certain eligibles on a full risk-capitated basis. The State must license all HMOs that contract with DMA.

For all of these healthcare models the objectives are:

- cost-effectiveness
- appropriate use of healthcare services
- improved access to primary preventive care

Maternity and Child Health

Providing preventive medical services and basic medical care for mothers and children is a continuing priority for the Medicaid program and for the State of North Carolina. Medicaid covered 56,227 of the 117,273, or 47.9 percent, of all live births in North Carolina during SFY 2003 (the most recent fiscal year for which data were available). Medicaid coverage is federally mandated for children with family incomes below 100 or 133 percent of the federal poverty level, depending on the age of the child. Over the years, North Carolina has taken advantage of federal options to expand Medicaid coverage to pregnant women and children with incomes ranging up to 185 percent of the poverty level. Since implementing the initiatives and programs described below,

North Carolina has experienced many positive outcomes, including reductions in the infant mortality rate and better access to preventive health care for Medicaid recipients and low-income children.

Baby Love

Baby Love was implemented in 1987 and is administered jointly by the Division of Medical Assistance (DMA) and the Division of Public Health (DPH). The program provides pregnant women with comprehensive care through an expanded Medicaid benefit package, which includes targeted case management services, childbirth education classes, in-home nursing care for high-risk pregnancies, medical nutritional therapy, health and behavior intervention, and postpartum/ newborn home visits. Specially trained nurses and social workers called Maternity Care Coordinators assist the women in accessing medical care and support services. In addition, Maternal Outreach Workers, who are specially trained to assist at-risk families, are available in 58 counties.

Evaluations of the Baby Love Program have shown that women who receive Maternity Care Coordination services average more prenatal visits per pregnancy, have a higher participation rate in the WIC program, experience better birth outcomes, and are more likely to receive postpartum family planning services. Likewise, their children are more likely to receive well-child care and WIC services.

Health Check

In 1993, North Carolina expanded the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program to form Health Check. Health Check encourages regular preventive health care and the diagnosis and treatment of any health problem detected during a screening. Medicaid recipients under the age of 21 are automatically eligible for Health Check services.

An integral part of the Health Check program is a special initiative called the Health Check Outreach Project. Specially trained Health Check Coordinators work through this program to reduce barriers and educate families on the importance of preventive health services. Recently, a plan was endorsed by the NC Health Directors' Association to expand Health Check Coordinators statewide. This plan will eventually place Health Check Coordinators in all counties by reallocating existing positions. Currently, Health Check Coordinators are located in 89 counties as well as the Qualla Boundary (the reservation of the Eastern Band of Cherokee).

DMA's Managed Care Section is the administrative entity for the Health Check Program and coordinators. The Managed Care Section works closely with the Division of Women and Children's Health to provide guidance to the counties.

The Health Check Automated Information and Notification System (AINS) is a computerized system for identifying and following the health care activities of Medicaid-eligible children. It enables Health Check Coordinators to determine which Medicaid-eligible children in their respective counties are receiving regular and interperiodic Health Check screenings, immunizations, and referrals for special health care problems. AINS generates notices to the parents of Medicaid-eligible children, notifying them of the Health Check Program, scheduled screening appointments, immunizations, and available programs and services. For children enrolled in a Medicaid managed care program, the name of the Community Care primary care provider or the HMO appears on letters sent to providers to whom referrals are being made. Access to and utilization of health care services for Medicaid-eligible children and youth have improved since the program was initiated.

Local Education Agencies

Medicaid is a critical source of health care coverage for children. Thus in order to assure that a comprehensive array of services is accessible to the children, Medicaid pays for certain health related services provided within the public schools and Head Start Programs. The school setting provides an opportunity to enroll eligible children in the Medicaid program as well as assist children who are already enrolled in Medicaid to access benefits that may be available to them. Medicaid pays for certain health-related services that are provided to these children at considerable costs to State and Local school districts. Direct Medical

Services that are currently available within the LEA and Head Start Program setting are Audiology, Speech/Language, Occupational Therapy, Physical Therapy and Psychological/Counseling Services. Nursing, an additional service is in the process of being added. In addition to providing funding for the direct medical service, Medicaid also provides reimbursement for Administrative activities in support of delivering the direct medical service. Providing funding for these services within the school environment, improves access of these services to eligible children whom otherwise may not be able to obtain these medically necessary services.

Practitioner and Clinical Services

Practitioner and Clinical Services comprise services provided by:

- ambulance services
- ambulatory surgery centers
- anesthesiology services
- birthing centers
- chiropractors
- clinic services
- dialysis services
- labs
- maternity care coordination services
- nurse practitioners
- outpatient hospital services
- physicians
- podiatrists
- radiology services

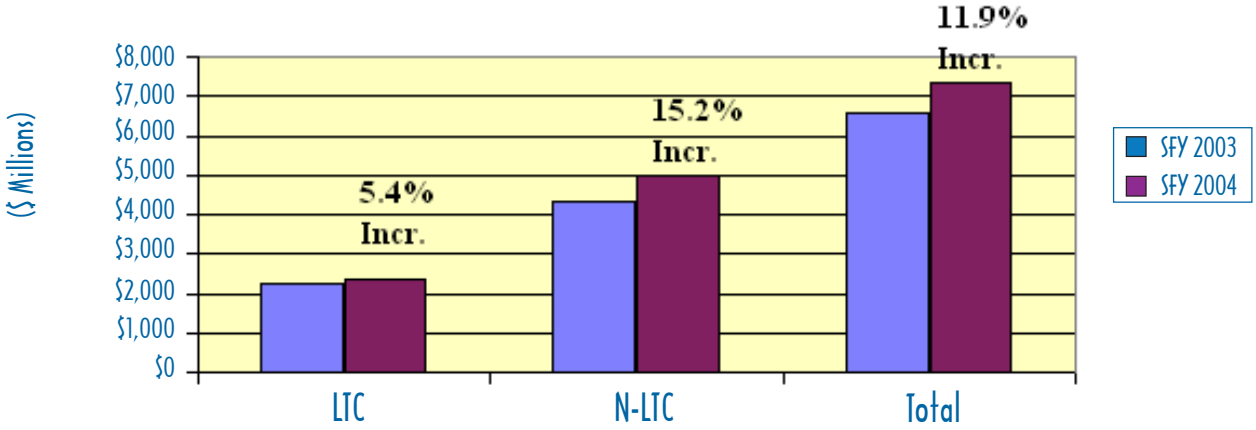
The annual updates of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes occur in this program area. During this fiscal year, staff completed the intense process of documenting all current policies and provided the necessary input for the construction of the new MMIS+ system.

Long Term Care

The N.C. Medicaid program spends a large portion of its service dollars (approximately 32 percent) on long term care. Long term care includes institutional care (all intermediate and skilled nursing facility and hospital long term care) and home and community based care (home health, durable medical equipment, Community Alternatives Programs, home infusion therapy hospice, adult care home and personal care services). As shown in Exhibit B-1, total expenditures for long term care during SFY 2004 were approximately $2.4 billion, an increase of 5.4 percent over the previous year.

Exhibit B-1

NC Medicaid Long Term Care vs. Non-Long Term Care Expenditures – SFY 2003 vs. 2004 ($ Millions)



Facility Care Services

Nursing Facility Care

There are times when nursing facility care is the best option for Medicaid recipients. All Medicaid-certified nursing facilities are required to provide skilled nursing (SN) care. Nursing facility reimbursement rates are based on the average state nursing facility per diem rate. The rates are determined by use of the Resource Utilization Groups-III, case mix reimbursement system.

Medicaid allows an individual with a spouse living in a nursing facility to keep a larger portion of the couple's income than normally allowed under Medicaid eligibility rules. This allows an institutionalized spouse to receive Medicaid without impoverishing the at-home spouse. The income of the spouse living at home is considered in determining whether an allowance is budgeted. The total income and resources amount that may be protected for the at-home spouse increases each year.

All Medicaid recipients must receive prior approval before admission to a nursing facility. Prior approval is given only if recipients meet the State's stringent medical criteria for admission. There is also a federal requirement for preadmission screening and annual resident review (PASARR) to screen and evaluate applicants and residents of Medicaid-certified nursing facilities for mental illness, mental retardation, developmental disabilities, and related conditions.

In SFY 2004, a total of 30,602 Medicaid recipients received skilled care in nursing facilities costing $479 million. A total of 21,505 recipients received intermediate care in nursing facilities costing $418 million.

Intermediate Care Facilities for the Mentally Retarded

Intermediate Care Facilities for the Mentally Retarded (ICF-MR) facilities are long term care facilities for the mentally retarded/ developmentally disabled who meet certain federal criteria. The criteria include the need for active treatment for individuals who have mental retardation or a related condition and who have a severe, chronic disability. ICF-MR facilities must meet certification requirements relating to the provision of habitable services as well as basic intermediate care services. ICF-MRs are paid prospective per diem rates. During SFY 2004, a total of 4,580 recipients were treated in ICF-MRs at a total cost of $414 million.

Adult Care Home Personal Care Services

Since 1995, NC Medicaid covers Basic Personal Care Services for residents in Adult Care Homes who are eligible for Special Assistance for Adults (SA) and Medicaid. It has covered Enhanced Personal Care Services since 1996 for residents of Adult Care Homes who meet Medicaid criteria for being a "heavy care" resident.

In SFY 2004, a monthly average of 20,060 persons received Basic Personal Care Services at an annual cost of $121 million. Another monthly average of 3,598 North Carolinians received Enhanced Personal Care Services in Adult Care Home settings at an annual cost of $9 million. Additionally, a monthly average of 19,738 persons received non-medical transportation services related to the Adult Care Home program at an annual expense of $4.5 million.

Home and Community-Based Services

Home and community-based long term care is a cost-effective and preferable alternative to institutionalization. Medicaid recipients can receive several home-based services such as home health, personal care services, home infusion therapy and hospice.

Home Health

Home health services include medically necessary skilled nursing care, specialized therapies (physical therapy, occupational therapy, and speech therapy), home health aide services, and medical supplies needed for diagnosis, treatment or rehabilitation of a patient's illness in the home setting when provided by a Medicare Certified Home Health Agency. The services may be provided in the patient's private residence or in an adult care home (exception: home health aide services in the adult care home). The services are considered part time and intermittent and must be under a plan of care authorized by the patient's physician. In SFY 2004, a total of 13,975 recipients were served at a cost of $99 million.

Hospice

Hospice services, which are elected by the recipient, is a benefit package of medical and support services for terminally ill individuals. An individual is considered terminally ill if he or she has a medical prognosis of a six month or less life expectancy as certified by a physician. The services include nursing care, medical social services, counseling, the professional care of a physician, home health aide and homemaker services, physical and occupational therapy, speech-language pathology, medical appliances and supplies, drugs and biologicals, and short-term inpatient care (general and respite) when related to the terminal illness. The services are provided in a private residence, an adult care home, a hospice residential care facility or a hospice inpatient unit. The services also may be provided in a hospital or nursing facility under arrangement with the hospice agency. In SFY 2004, an average monthly total of 890 recipients were served at an annual cost of $31.6 million.

Home Infusion Therapy

Home Infusion Therapy (HIT) coverage provides for infusion nursing service, pharmacy services, medical equipment, supplies and training. HIT is for self-administration (by the recipient or unpaid caregiver) of a drug or nutrition therapy such as total parenteral nutrition, pain management or antibiotics. The route of administration may be intravenous, enteral, parenteral, intrathecal or epidural. HIT coverage is for recipients who live in a private residence or an adult care home. In SFY 2004, a monthly average of 354 recipients were served at an annual cost of $6.8 million.

Private Duty Nursing

Private Duty Nursing (PDN) coverage is for recipients who live in a private residence and require substantial and complex continuous skilled nursing care as ordered by the attending physician. PDN must be prior approved and be supported by a physician's letter of medical necessity.

Personal Care Services

Personal Care Services (PCS) covers personal aide services in private residences to perform personal care tasks for recipients who, due to a debilitating medical condition, need help with such basic personal activities as bathing, toileting, and moving about. Aides also monitor the patient's vital signs. Services may also include housekeeping and home management tasks that are integral, although secondary, to the personal care tasks necessary for maintaining the patient's basic personal health. PCS is provided for the patient according to a physician's authorized plan of care. Recipients are eligible to receive up to 60 hours of PCS per month depending on their needs. Recipients who receive prior approval from DMA may be eligible for an additional 20 hours of PCS if they meet more stringent eligibility criteria. These additional hours are available through the PCS-Plus program.

HIV Case Management

HIV Case Management (HIV CM) is a targeted case management program funded by NC Medicaid. The program is owned jointly by DMA and DPH. While DMA has administrative oversight of the program, the day-to-day operations are managed by the AIDS Care Unit within DPH. In SFY 2004, a monthly average of 1,175 recipients were served at an annual expense of $6.8 million.

Community Alternatives Program

Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities

Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD) is a special Medicaid home and community-based "waiver" program. It was implemented in 1983 to serve individuals who would otherwise qualify for care in an ICF-MR. It allows these individuals the opportunity to be served in the community instead of residing in an institutional setting. The Medicaid cost for community care must be cost effective in comparison to the cost of ICF/MR care. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services manages the daily operation of the program under an agreement with DMA. The program is available statewide through local area mental health, developmental disabilities and substance abuse programs. CAP-MR/DD served a monthly average of 5,518 people in SFY 2004 at an annual cost of $266 million. The average monthly cost per recipient of CAP-MR/DD services was approximately 40 percent of the average cost of care at a state-owned ICF/MR facility and 61 percent of that at a non-state-owned facility.

Community Alternatives Program for Children

Community Alternatives Program for Children (CAP/C) is a Medicaid waiver program which provides home-based care for medically fragile children through age 18. Participants must meet criteria for medical necessity and must be at risk for institutionalization. CAP/C provides skilled nursing or "in-home" aides, case management and waiver services. The case manager is responsible for developing a plan of care and a budget that is based on the level of care determination. In SFY 2004, a monthly average of 551 recipients were served at an annual cost of $24 million.

New level of care budget limits were established for SFY 2005 at $2,630 for intermediate care, $3,437 for skilled care, and $28,679 for hospital level of care for SFY 2005.

Community Alternatives Program for Persons with AIDS

Community Alternatives Program for Persons with AIDS (CAP/AIDS) provides home based care for persons with AIDS. This waiver program is a cooperative effort between DMA and DPH. The AIDS Care Unit, within DPH, handles the program's operation, including approving plans of care, with DMA providing oversight. Local CAP/AIDS case management agencies are the entry point. There is a federal limit on the total unduplicated number of participants

each year. The program provides an alternative to nursing home placement. To be eligible for participation, the following must meet certain medical criteria. If approved for the program, recipients are potentially eligible for special waiver services in addition to regular Medicaid services. In SFY 2004, a monthly average of 66 recipients served at an annual expense of $1.4 million.

Community Alternatives Program for Disabled Adults

Community Alternatives Program for Disabled Adults (CAP/DA) provides a package of services to allow adults, ages 18 and older, who qualify for nursing facility care, to remain in their private residences. CAP/DA experienced significant growth for many years as DMA pushed its expansion into all counties and fostered the growth of existing county programs. CAP/DA has been the state's primary answer to controlling the growth of nursing facility expenditures while addressing quality of life issues for the expanding frail elderly and disabled adult population. CAP/DA offers North Carolina the only significant avenue for addressing Olmstead issues for the frail elderly and physically disabled adults. The program served a monthly average of 8,799 citizens in SFY 2004 at a yearly cost of $202 million. The legislature continues to support the program and has authorized additional program funding for SFY 2005 which will enable the CAP/DA to serve an additional 2,500 individuals during the year.

Ancillary Services

Durable Medical Equipment

Medicaid pays for Durable Medical Equipment (DME) when it is medically necessary for a recipient to function in his home or an adult care home. The list of covered items includes wheelchairs, hospital beds, blood glucose monitors, ambulation devices, enteral formulas, bedside commodes, oxygen and respiratory equipment, and miscellaneous supplies used with DME. Orthotic and prosthetic devices, including braces and artificial limbs, are covered for recipients from birth through age 20. The patient's physician must order DME and document medical necessity on the Medicaid Certificate of Medical Necessity and Prior Approval form. Some items require prior approval. All DME and related supplies have established lifetime expectancies and quantity limitations.

Independent Practitioner Program

The Independent Practitioner Program enrolls and reimburses individual independent practitioners to provide physical therapy, occupational therapy, respiratory therapy, speech and language therapy, and audiological services to children from birth through 20 years of age.

Optical Services

The Optical Services Program is responsible for the overall administration of visual services covered in the NC Medicaid Program. Medicaid covers routine and medical eye examinations, corrective eyeglasses, medically necessary contact lenses and some other visual aids. Prior approval is required for all visual aids and is recommended for routine eye examinations. There are limitations regarding the frequency of eye examinations and the number of dispensed visual aids during specific eligibility periods. A $3 copayment is applicable to ophthalmologist visits, while a $2 copayment applies to optical services and supplies. Although a $2 copayment is generally required for new eyeglasses, eyeglass repairs and contact lenses, there are some exemptions.

Medicaid eyeglasses are supplied through a contractual agreement with the NC Department of Correction Enterprise, Nash Optical. Providers must obtain Medicaid eyeglasses through this laboratory. Prior approval for exceptions may be granted under extenuating circumstances.

Hearing Aid Services

Single and binaural hearing aids are covered for recipients under 21 years of age that have received medical clearance from a physician. An ENT specialist, otologist, otolaryngologist, audiologist or hearing aid dealer must submit a prior approval request for the hearing device, audiogram, evaluation report and manufacturer's warranty information. Each prior approval request for replacement hearing aids due to hearing changes, damaged hearing aids or lost hearing aids is reviewed

individually for medical necessity. Providers may seek prior approval for FM systems for recipients from birth up to the time of school enrollment. There are no co-payments for hearing aids, hearing aid accessories, or hearing aid services.

Behavioral Health

NC Medicaid covers a variety of services for behavioral health, some under the rehabilitation option and others under the clinic option. Services provided under the rehabilitation option are provided by area mental health centers and include:

outpatient therapy
psychological testing
day treatment
partial hospitalization
psychosocial rehabilitation
facility-based crisis
community-based services for recipients of all ages
residential services for recipients under the age of 21

Clinic services include outpatient therapy and psychological testing provided by directly enrolled providers, hospitals, health departments, physicians, and local education agencies (LEAs). Medicaid also covers inpatient psychiatric care in community hospitals for recipients of all ages and in free-standing psychiatric hospitals and psychiatric residential treatment facilities (PRTFs) for recipients under the age of 21.

Inpatient services, residential services, and outpatient therapy must go through a prior approval process. (Refer to the Behavioral Health Prior Approval subsection under the Utilization Management section of Addendum A: How the NC Medicaid Program Works for additional information.)

DMA also provides services in intermediate care facilities for the mentally retarded (ICF-MRs), which are long term care facilities for individuals with mental retardation or a related condition that occurred before the age of 22. (Refer to the Intermediate Care Facilities for the Mentally Retarded (ICF-MR) subsection of the Long term Care section of Addendum B: Initiatives and Subprograms for additional information.)

Dental Health

NC Medicaid covers most diagnostic and preventive dental services such as exams, radiographs, dental cleanings, fluoride treatments, and sealants. Dental restorations, root canals, periodontal services, oral surgeries, and partial and full dentures are covered in addition to orthodontic services for children under age 21 with functionally handicapping malocclusions. Most dental services do not require prior approval. Except where a coverage category is exempted from copayments by law, recipients are charged a $3 copayment per visit. A special children's initiative to decrease the incidence of early childhood caries was implemented statewide effective February 1, 2001. This program, allows children from birth to age three to receive a limited set of preventive dental services provided by specially trained physicians and local health departments.

Pharmacy Services

Drug Use Review Program

NC Medicaid established a Drug Use Review (DUR) Program as required by OBRA of 1990 to ensure that outpatient drugs dispensed to Medicaid recipients are appropriate, medically necessary, and are not likely to result in adverse medical effects. The DUR program is characterized by the following four major components:

- **DUR Board** – A DUR Board is composed of five licensed and actively practicing physicians, five licensed and actively practicing pharmacists, two other individuals with expertise in drug therapy problems, and the DMA DUR Coordinator. The DUR Board makes recommendations to DMA on DUR policies and procedures.

- **Prospective DUR** – Prospective DUR requires that, prior to dispensing, the pharmacist must screen for potential drug therapyproblems and counsel patients about the medications they are taking in order to enhance patient compliance.
- **Retrospective DUR** – Retrospective DUR is an ongoing periodic examination of Medicaid claims data and other records to identify patterns of behavior involving physicians, pharmacists, and individual Medicaid recipients associated with specific drugs or groups of drugs and the appropriate treatment of disease states. These analyses are based on predetermined standards established by the DUR Board. Our DUR vendor contract is with the University of North Carolina School of Pharmacy
- **Education** – Education is the key to an effective DUR Program. The DUR Program must provide ongoing outreach programs to educate physicians and pharmacists about common drug therapy problems with the goal of improved prescribing and dispensing practices.

The DUR Program uses a Provider Profiling System and ad hoc reporting to complement the retrospective patient-based drug utilization reviews. The Provider Profiling System, criteria driven, identifies prescribing and dispensing practices that deviate from accepted norms. These norms may be defined by the Board, taken from published literature or pre-determined standards. The primary focus of the DUR Program is educating providers about common drug therapy problems to improve prescribing and dispensing practices

Outpatient Pharmacy Program

Prescription drugs, insulin, and selected over the counter (OTC) products (where the manufacturers have signed a rebate agreement with CMS) are covered under the pharmacy program. Recipients may have up to six prescriptions per month and are locked into one pharmacy provider during the month of service. A recipient co-payment of $1 applies for generic and selected OTC medications and $3 for brand medications.

NC Medicaid does not pay for a drug to be refilled during the same month that the prescription is originally filled except for cases in which medication has been lost. Recipients may have a 34-day supply of their prescription medication and a 3-month supply of birth control pills (BCP) and hormonal replacement therapy (HRT) dialpaks. Effective October 2003, Medicaid recipients were able to obtain a 90 day supply of a medication at the discretion of the prescriber if the claim is for a generic, non-controlled maintenance medication (listed on the FUL or SMAC) if the recipient had a previous 30 days fill for the same medication.

The pharmacy reimbursement fee structure is as follows: AWP (average wholesale price) less 10 percent, State MAC, Federal Upper Limit (FUL) or Usual and Customary, whichever is lower, plus a dispensing fee of $5.60 per generic and selected OTC products or $4.00 per brand name prescription.

In November 2003, the State implemented a statewide Prescription Advantage List (PAL). The PAL's methodology is to take the top 15 most costly therapeutic drug classes and place them in 3 tiers according to their net cost to NC Medicaid. This is a voluntary collaborative initiative between all provider groups

Medicare-Aid

In February 1989, the N.C. Medicaid program began a new limited Medicaid program for Qualified Medicare Beneficiaries. The program, known as Medicare-Aid, provides assistance to eligible individuals with Medicare cost-sharing expenses, such as deductibles, premiums, and coinsurance charges. The eligibility income limit for Medicare-Aid is 100 percent of the federal poverty level. This level is adjusted in April of each year.

Effective January 1, 1993, the Medicare-Aid program was expanded to include qualified individuals with income greater than 100 percent of the federal poverty level but not greater than 120 percent. These individuals are referred to as Specified Low-Income Medicare

Beneficiaries. Eligible individuals in this group receive assistance with the payment of their Medicare Part B premium only.

In January 1998, the Medicare-Aid program was further expanded to include a new group of Medicare beneficiaries. Referred to as "Qualifying Individuals," they have incomes between 121 percent and 135 percent of the federal poverty level and receive assistance with 135 percent of the federal poverty level and receive assistance with the payment of their Medicare Part B premiums. Funding for these groups is capped and approval of assistance is based on a first-come first-served basis.